

STATE OF MAINE
BOARD OF PHARMACY
APPLICATION FOR REGISTRATION

- **MANUFACTURER**
- **WHOLESALE**
- **WHOLESALE DISTRIBUTOR**



Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689 or (207) 624-8620
TTY/HEARING IMPAIRED (207) 624-8563
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: kelly.l.mclaughlin@maine.gov

APPLICANTS FOR REGISTRATION MUST SUBMIT THE FOLLOWING:

- Completed application and \$200 non refundable registration fee. Make all checks payable to Treasurer, State of Maine;
- Copy of list of officers to include names, titles, addresses, and telephone numbers;
- Copy of the last inspection report from the state licensing in which the registrant is located; and
- Verification of licensure from every state in which the licensee currently holds or has ever held.

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if the application is incomplete, supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BOARD OF PHARMACY

35 STATE HOUSE STATION

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John Elias Baldacci
GOVERNOR

Anne L. Head
DIRECTOR

APPLICATION FOR REGISTRATION

TYPE OF REGISTRATION (*check one*) \$ 200 PAYABLE TO: TREASURER, STATE OF MAINE

- ☐ WHOLESALE DISTRIBUTOR ☐ MANUFACTURER
☐ WHOLESALER

PLEASE CHECK ONE:

- ☐ INITIAL APPLICATION
☐ CHANGE OF OWNERSHIP/LOCATION Current registration #: _____

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Please print or type:

NAME OF
BUSINESS: _____

PHYSICAL
LOCATION: _____
STREET

CITY

STATE

ZIP CODE

NOTE: ALL CORRESPONDANCE WILL BE SENT TO THE PHYSICAL LOCATION.

CONTACT

ADDRESS: _____

CITY

STATE

ZIP CODE

TELEPHONE #: _____ FEDERAL TAX I.D. #: _____

EMAIL

ADDRESS: _____

CURRENT STATE LICENSE #: _____ EXPIRATION DATE: _____
(in the state you are currently operating)

DEA #: _____ EXPIRATION DATE: _____

WORLD WIDE WEB ADDRESS/UNIFORM RESOURCE LOCATORS (URL):

TOLL FREE CUSTOMER ACCESS TELEPHONE NUMBER:

PERSON RESPONSIBLE FOR STORAGE, HANDLING, AND DISTRIBUTION OF
PRESCRIPTION DRUGS, CONTROLLED SUBSTANCES, AND NARCOTICS:

NAME: _____

—

CONTACT

ADDRESS: _____

TELEPHONE #: _____

PLEASE LIST ALL TRADE OR BUSINESS NAMES USED BY REGISTRANT:

A. _____

—

B. _____

—

C. _____

OWNERSHIP STATUS must include list of officers with names, titles, addresses, and telephone numbers.

A. IF INDIVIDUAL, STATE NAME:

B. IF PARTNERSHIP, STATE FIRM NAME: (A list of all partners including name, title, address, and telephone numbers must be provided)

NAMES OF PARTNERS:

C. IF CORPORATION, STATE NAME: A list of officers including name, title, address, and telephone numbers must be provided.

NAMES OF OFFICERS:

NOTE: Attach a separate sheet of paper (8 1/2" x 11") paper if additional space is needed

LIST BELOW EVERY STATE WHICH THIS ENTITY HAS EVER HELD OR CURRENTLY HOLDS A LICENSE:

STATE, TERRITORY, COUNTRY

LIC/REG NUMBER

DATE ISSUED

EXPIRATION
DATE

ATTACH A SEPARATE PIECE OF PAPER IF ADDITIONAL SPACE IS NEEDED

**** You must also send the enclosed Verification of Licensure form each state licensure board where you hold or have held a license. Please follow directions on the form.**

Check appropriate response to the questions below. Any **YES** response must be fully explained by written statement on a separate sheet of paper (8 1/2" x 11"), signed and dated, and submitted with your application.

Has any jurisdiction taken disciplinary action against your professional license/registration or denied your application for licensure? ☐Yes ☐No

Have you or any corporate officers ever been convicted of a crime other than a minor traffic violation? ☐Yes ☐No

Has this entity ever been denied registration by the u.s. drug enforcement administration (DEA) or has it's DEA registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to dispense controlled substances? ☐Yes ☐No

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

By submitting this application I understand that the Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

PRINT NAME

SIGNATURE OF APPLICANT

DATE

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary.)

Applicant

Name: _____

Address: _____

(state)

(zip code)

License #: _____ Date Issued: _____

I hereby authorize the Board of Pharmacy of the State of _____
to furnish to the Maine State Board of Pharmacy the information requested below.

Applicant Signature:

Date:

To be completed by the State Licensing Board verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named was issued:

License #

Date issued

Date of expiration

Current Status of License: (check all that apply) ☐Active ☐Inactive ☐Lapsed
☐Probation ☐Restricted ☐Suspended ☐Revoked

Disciplinary Action: (If yes, please attach a copy of the decision and a detailed explanation for the discipline and a copy of the consent agreement(s) or decision & order(s) issued)

Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way or is it currently under investigation? ☐ Yes ☐ No

Date of last inspection: _____

Has any inspection of the applicant resulted in deficiency ratings? ☐ Yes ☐ No

Signature: _____

Title: _____

State completing this form: _____

Date: _____

(SEAL)



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AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Mailing Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:		Telephone #:
Name of cardholder: (if other than applicant)		
Mailing Address: (if other than applicant)		
City:	State:	Zip Code:

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ Visa ☐ MasterCard _____

Card number _____
Expiration date: ____/____/____ in the amount of: \$ _____

Signature: _____ Date: ____/____/____